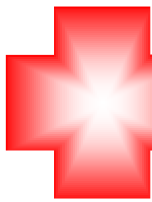

Emergency Care Plan

FOOD ALLERGY

Student: ______________________________________ Grade: ______ DOB: ___________

Asthmatic: ❑ Yes ❑ No (increased risk for severe reaction) Allergen(s): ______________________________

Parent #1: _________________________ Home #: _________ Work #: __________ Cell #: __________

Parent #2 _________________________ Home #: _________ Work #: __________ Cell #: ______

Emergency Contact: ________________________ Relationship: _____________ Phone: ______________

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth, mouth "feels hot"
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse," "passing out"

The severity of symptoms can change quickly –
it is important that treatment is give immediately.

TREATMENT: Rinse contact area with water if appropriate

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms

Benadryl ordered: Yes ___ No ___ **Dosage Schedule**: ______________________________________
*self-carry Yes ___ No ___
____

Epinephrine ordered: Yes ___ No ___ **Dosage Schedule**: ______________________________________
*self-carry Yes ___ No ___
____

IF INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Preferred Hospital if transported: ___________________________
Epinephrine provides a 20-minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian, or emergency contact is not present and adequate supervision for other students is present. Call school nurse / parent if off school grounds.

*I attest that this student has demonstrated to me that they can self-administer this medication.

Physician's Signature____ Date: ______________

Physician's Name (please print) ____ Phone: _____________

Parent/Guardian Signature: ____ Date: _____________

** This plan will be shared with pertinent staff on an as need to know basis.

This plan is in effect for the current school year and summer school as needed. Revised 9/2022